

15

**THE CURE OF THE "INCURABLE,"
A PLEA FOR MORE ACCURATE
DIAGNOSIS AND MORE CARE-
FUL PROGNOSIS IN MALIG-
NANT DISEASE**

BY
**WILLIAM SEAMAN BAINBRIDGE, A. M.,
Sc. D., M. D., C. M.**
New York City



Reprint from
AMERICAN MEDICINE
New Series, Vol. X, No. 7, Pages 525-534
July, 1915

298

**THE CURE OF THE "INCURABLE,"
A PLEA FOR MORE ACCURATE
DIAGNOSIS AND MORE CARE-
FUL PROGNOSIS IN MALIG-
NANT DISEASE.**

BY

WILLIAM SEAMAN BAINBRIDGE, A. M., Sc.
D., M. D., C. M.
New York City.

There is perhaps no disease in which the diagnosis is fraught with so many snares, and in which the prognosis may lead to so many pitfalls, as cancer. Unfortunately, the diagnosis is often attained by no absolutely reliable sign or symptom, or set of signs or symptoms. The study of the clinical course of the disease and a knowledge of the difficulties involved in making a reliable diagnosis must emphasize the importance of giving the patient the benefit of the doubt as to the prognosis, on the positive as well as on the negative side. While the so-called classic symptoms of malignancy are often present, there may be one or all absent in the presence of a tumor which is plainly and perhaps virulently malignant, as determined by careful mi-

croscopical examination. It is equally certain that these symptoms may be present to a marked degree coincidentally with the existence of a tumor or tumors the non-malignant nature of which may be established by the complete disappearance of the neoplasm under treatment directed toward causative factors in no way involving the existence of a malignant process.

It is clear then that no symptoms or set of symptoms should be relied upon invariably in making a diagnosis of cancer. Unless the clinical picture is absolutely convincing, especially in cases involving extensive surgery, the microscopical should always be employed to reinforce the clinical diagnosis, if it is at all feasible to do so. In the presence of a clear-cut clinical picture of malignancy, involving radical surgery, a negative microscopic report should not be accepted as final. Every surgeon whose experience with cancer is extensive, has doubtless had repeated evidence that malignancy may be discovered in some instances by the aid of the microscope only after many sections have been examined.

Inasmuch as there is at present no reliable serodiagnostic test for cancer, there must be brought to bear upon every case in which there is room for doubt a careful

correlation of clinical and laboratory methods of diagnosis.

The fact that about eight to nine per cent. of patients operated upon for cancer, or sent to the mortuary as dead of the disease, in a certain set of hospitals employing modern methods during a given period of time,¹ were not victims of this disease, is very significant of the need of more accurate diagnosis, and more careful prognosis. The findings in these hospitals could, without doubt, be paralleled in many others, and in the private practice.

The converse of this state of affairs is doubtless likewise true, though it is not so easy to determine the number of cases of cancer which were originally diagnosed as nonmalignant affections of one kind or another. Such cases, as a rule, eventually come to the surgeon at the stage of the disease when mistake is improbable or impossible, and the errors of the previous diagnostician are not recorded.

Mistakes in diagnosis of either kind may be very disastrous in their outcome, and it is only by the careful weighing of the evidence in each case that they may be avoided. Indifference to the gravity of an affection which bears semblance to cancer is extremely reprehensible, whether the pa-

¹ Bainbridge, "The Cancer Problem," 1914, pp. 195-196.

tient be the humblest occupant of the hospital ward or the proudest "lord of the castle." On the other hand, a reckless tendency to be on the safe side and to treat as cancer every harmless lump and bump may be far-reaching in its evil consequences.

The difficulties which beset the physician or surgeon as diagnostician in the matter of determining the question of malignancy or nonmalignancy, are not all that he is liable to encounter. As prognosticator he is prone to carry his patients too far into the high places of hope by treating as trivial matters which are of grave import; or he is apt to plunge them too deeply into the slough of despond by pronouncing as hopeless conditions those which may be curable, or at least amenable to palliation.

From the point of view of diagnosis, treatment, and prognosis it may be convenient to classify cases of cancer under the following heads: (1) Removable, hence curable; (2) *seemingly* irremovable and incurable; (3) irremovable yet operable and curable; (4) irremovable and incurable, yet operable; (5) inoperable, irremovable, and incurable. The study of a few cases of each category would serve to convince the most sanguine investigator that there is an urgent call for more accurate diagnosis and more careful prognosis, not only with re-

gard to the existence of malignancy, but as to the stage to which it has developed. The following cases are presented as illustrations of some of the diagnostic and prognostic stumbling blocks which may be encountered.



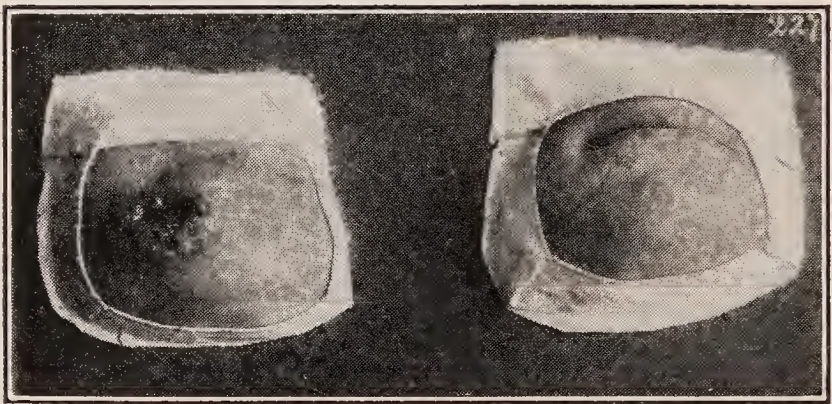
CASE 1. Fig. I.

Case 1. F., male, 40 years of age. Cigar salesman, and an inveterate smoker. Consulted me November 22, 1913, for the condition of the lower lip shown in Fig. 1. Photograph of a wax cast of the condition. Two or three years before he had had several small sores on his lip, which his physician had cleared up by the use of caustics. In the present instance he had previously consulted two other physicians, one of whom pronounced it cancer and advised immediate removal of the growth, the other, a surgeon, urged excision of the lip and glands of the neck. Upon examination I found ulceration of the mucous membrane of the lower lip, along the line of the

teeth. Wassermann reaction proved positive, and the patient was placed on mixed treatment. Within a month all evidence of syphilis disappeared from the lip.

Even the most expert may make mistakes in diagnosis, but the aim should always be toward the minimum of errors of this kind. More care in the diagnosis in this case would have cleared up the nature of the trouble. Furthermore, if the condition had been cancer, the use of a caustic was ill-advised; if it were due to syphilis, the caustic would do no good. The use of the caustic, too, masked the signs of the disease that were really present.

Case 2. S., female, 43 years of age, was referred to me by her family physician, March 9, 1908, for diagnosis and treatment of the condition shown in Fig. 2-A. The patient gave the history of having cut the lower lip slightly in August, 1908, and of the development thereupon of the ulcer shown in the picture. She consulted sev-



CASE 2. Fig. II.

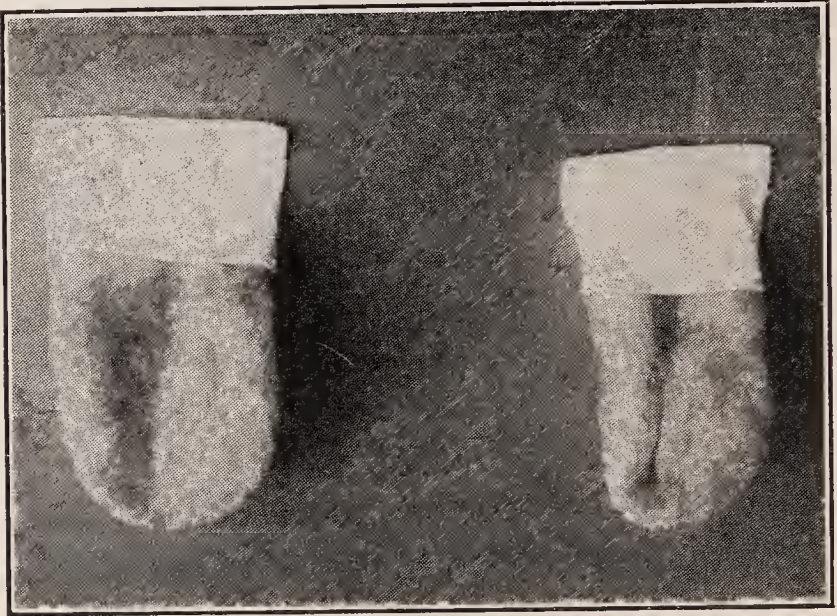
eral physicians, all of whom advised removal of the diseased area. A piece of tissue was removed from the ulcerated area and sent to a pathological laboratory for examination. The report was that "the diagnosis was tuberculosis. Epithelioid

cells, giant-cells, lymphoid elements and caseation are all present and the microscopical picture is that of typical tuberculosis. Syphilis, epithelioma and blastomycosis can be excluded." The report from another laboratory was to the effect that a careful search through the serum from the lip "has failed to determine the presence of the spirochete pallida. The serum obtained was of a very satisfactory sort for this examination." From a third laboratory came the following with reference to the examination of the specimen of blood: "It gave such an absolutely positive result to Noguchi's modification of the Wassermann reaction for syphilis that there can be no doubt of the presence of syphilis." Mixed treatment was administered for a few weeks, with disappearance of all signs of the disease, as shown in Fig. 2-B., which was taken from a wax cast of the lip made two months after the treatment was begun. She took medicine for over a year, and has been perfectly well ever since.

In either of these cases a cursory clinical examination might easily lead to the diagnosis of malignant growth. In the second case removal of the ulcer could have been effected with very little or no disfigurement, but it would not have cured the syphilis. To have removed the lip and the glands of the neck, as would have been the logical procedure had the condition been cancer, would have subjected the patient to unnecessary and absolutely useless disfigurement and suffering.

Case 3. F., male, 13 years of age, referred to me at the New York Polyclinic Hospital, February 23, 1915, by Dr. Louis Broter, for diagnosis and treatment. Ac-

according to the history, when the boy was eight months old his mother noticed a lump



A CASE 3. Fig. III. B

on the side of the tongue, about the size of a cherry. This was treated in Russia



CASE 4. Fig. IV.

by injections of some irritant that caused the tongue to swell. About four years ago, in his city, several small pieces were removed for examination, but the microscopic findings could not be ascertained, the physician who had charge of the case at that time reporting that the slides and the report of the pathologist had been lost. On several occasions the cautery was applied. Three doctors consulted pronounced the



CASE 4. Fig. V.

growth carcinoma, and advised removal of the tongue. When the symptoms were not acute, the condition was as shown in Fig. 3-A. There was a swelling about the size of a walnut over the right margin of the tongue, extending nearly to the center, the surface of this being irregular. Every two or three weeks there is an attack of acute inflammation of the tongue, sufficiently severe to cause the patient to go to bed.



CASE 4. Fig. VI.

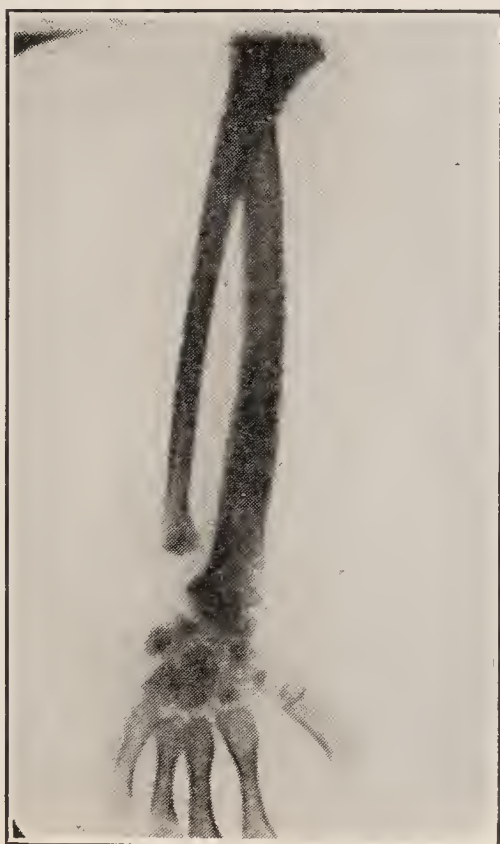
With proper precautions for preventing the encroachment upon healthy tissue, a section was removed for microscopic ex-



CASE 4. Fig. VII.

amination. The report was *lymphangioma of the papillomatous type*. Approximately one-third, longitudinally, of the tongue was removed, as shown in Fig. 3-B. Further examination of the section removed showed absolutely no vestige of carcinoma. The patient is perfectly well to-day.

In a patient of the so-called "cancer age" such a condition as this child presented,



CASE 4. Fig. VIII.

subjected for so long to what may justly be called the "tampering" method of treatment—injections, cauterization,—plus the constant irritation caused by rough food and the process of mastication, there is a strong possibility that malignant metamorphosis would have ensued. As it was, the boy was buffeted from the optimism which made possible in such a case the

dallying with the injections, caustics and the removal of sections for pathological study, to the pessimism which unqualifiedly pronounced the condition malignant and advised amputation of the tongue.

Case 4. W., female, three years of age when first seen by me, February 14, 1908. At that time she had a swelling of the right forearm, as shown in Fig. 4, and in Fig. 5. Fig. 6 shows the X-ray picture of the well



CASE 4. Fig. IX.

arm, for contrast. She was examined at six different hospitals and clinics, the diagnosis of osteosarcoma being made by all, and all advising amputation of the arm. Arrangements were made for the amputation at one of the New York City hospitals, but the child was taken away from the hospital by the mother at the last moment, as she said she would rather have the child die than go through life with one

arm. There was no history of syphilis, but as a precaution she was given active mixed treatment without results. Active tuberculin test also proved negative. Inasmuch as the mother refused operation, I placed the child on expectant treatment and kept her under observation. To my surprise, the swelling began to diminish in size. Fig. 7 shows the condition, as revealed by the X-ray, in 1912. Fig. 8, taken May 28,



CASE 4. Fig. X.

1915, by Dr. Lewis Gregory Cole, shows the present condition of the bone. Fig. 9 shows both arms taken for comparison. The X-ray report is as follows: "A very slight thickening of the cortex of the right radius and a shortening of about $\frac{3}{8}$ inch in the length of the ulna, together with a slight irregularity of the epiphyseal line, are the only remains of the very extensive lesion which was observed at the time of the

first examination." Fig. 10 shows the little girl's arms to-day.

Case 5. M., female, 21 months of age, when referred to me for diagnosis and treatment, by Dr. Daniel P. Maguire, Stapleton, N. Y., May 5, 1911. A year before the mother had first noticed a small swelling over the left tibia. She consulted several physicians, with varying results as to diagnosis and advice. Some believed there was sarcoma and advised radical



CASE 5. Fig. XI.

surgery. X-ray examination, (Figs. 11 and 12) at the time she was sent to me, made by Dr. Lewis Gregory Cole, showed "thickening of the cortex of the bone, more marked anteriorly, and beneath this, at the point indicated by the arrow (Fig. 12-A) in or near the medulla, is a small area of destruction of the bone, probably an abscess. . . . The structure of the bone in this case does not have the appearance of a specific lesion." Wassermann was

negative. Upon these findings the leg was opened and a small portion of the tibia removed, with a little dead bone. Microscopic study of the tissues removed gave no evidence of sarcoma or other new growth, and no indication of syphilis.

This case, with the preceding, illustrates excellently well the dangers of too cursory examination, and of the omission of any diagnostic test by which the true condition may be ascertained. Amputation, as was advised in each case, would have been a



CASE 5. Fig. XII.

great injustice, entailing a serious handicap upon these children.

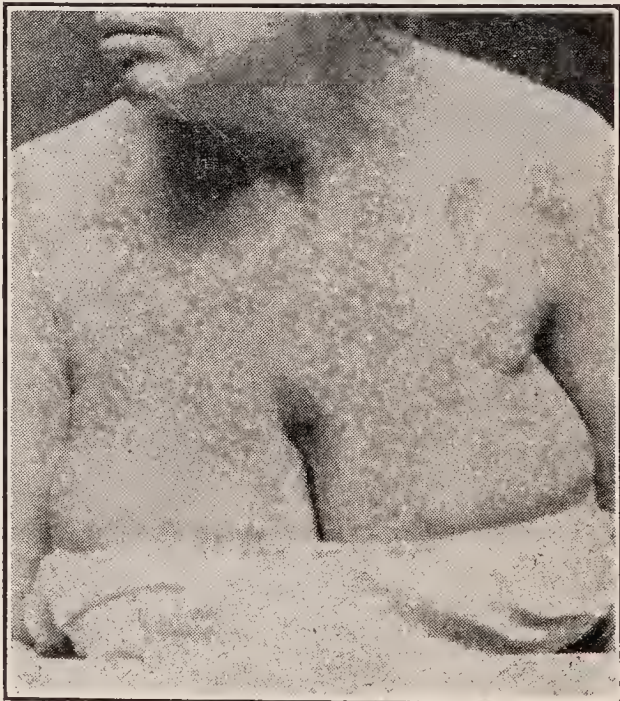
Case 6. C., 55 years of age. Referred to me by Dr. I. A. Stoloff, December 5, 1913. Three years before a lump appeared in the left breast, with nodules in the axilla. The nodules increased in size, and abscesses formed. She grew progressively worse. The abscesses were opened and the sinuses repeatedly curetted, by different physicians in different clinics and

hospitals. She soon began to lose flesh and strength. The entire left breast and chest wall became involved, with some swelling



CASE 6. Fig. XIII.

of the left arm. The nipple became retracted, as shown in Fig. 13. Six surgeons made the diagnosis of sarcoma. One made the diagnosis, "irremov-



CASE 6. Fig. XIV.

able sarcoma of chest wall—well disseminated malignancy,” and another refused her admission to his sanitarium, assuring her family that she had incurable cancer and had only a short time to live. Her pain finally became very severe, morphine was losing its effect, and Dr. Stoloff was called in by her family and begged to give her something to end her suffering. He insisted that she be sent to the hospital, whereupon she was sent to the New York Polyclinic Hospital, December 5, 1913. I made the diagnosis of tuberculosis, on the history and characteristics of the case. The tuberculous abscesses were not so large in the breast as in the chest wall, under the pectoralis major, so that what seemed to be a tumor of the breast was in reality the large abscesses behind the breast, pushing it forward. The abscesses were opened and curetted and she has been perfectly well since. Her present condition, as to the breast, is shown in Fig. 14.

Case 7. M., 65 years of age, married, no children. Consulted me, August 4, 1914. Six years before she first noticed a lump in the upper and outer quadrant of the left breast. This was not painful until two years before (1912), although the tumor had slowly increased in size. Her family physician pronounced it cancer, but advised against operation on account of her poor general condition and weak heart. Another physician gave her electrical treatment for two months, without benefit, then, at the hands of another, she was given an “injection treatment” for two years. She was assured that she had cancer, that it involved the lung, and that it was inoperable. For a number of years she had had “stomach trouble,” with pain and discom-

fort, and frequent vomiting. When she consulted me examination showed considerable tenderness over the stomach and ascending colon, a lumpy condition in the upper and outer quadrant of each breast. Radiographic examination confirmed the clinical diagnosis of chronic intestinal stasis. Laparotomy, November 9, 1914, further corroborated these findings. The lumps in the breasts were removed, and microscopic examination established their nonmalignant nature. There was no evidence of cancer anywhere. The patient developed post-operative pneumonia after laparotomy, and died, November 13, 1914. Autopsy showed absolutely no evidence of cancer.

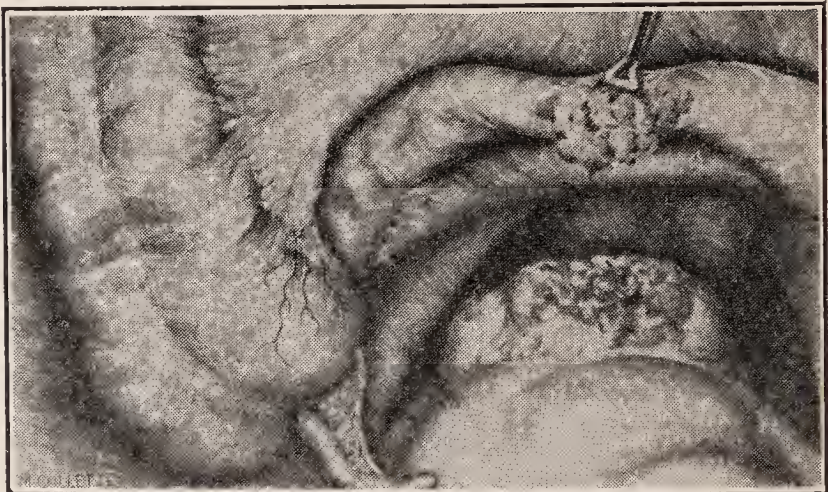
This case is an excellent illustration of the disastrous results of taking for granted the malignant nature of small tumors in the breast, allowing this diagnosis to obscure the underlying cause—the intestinal condition. Proper attention to the long-existent “stomach trouble” might have cleared up the lumpy condition in the breast, and would have obviated the necessity of a serious operation after the patient’s vitality was at such a low ebb. With a history of digestive disorders of long duration, a lumpy condition of the breast or breasts should always suggest the possibility of chronic intestinal stasis, and the patient, under most careful observation should be given the benefit of the prescribed dietetic, hygienic, and supportive treatment for this condition. If this fails to clear up the condition, laparotomy may be indicated. Numbers of these cases have been found to yield to such treatment, the lumps in the breast disappearing completely.

Case 8. H., 26 years of age, single. Consulted me November 2, 1914. In 1910 she first detected a lump in the left breast. This was more or less painful at times. It gradually grew until, in the fall of 1914, it was the size of a mandarin orange. Her family physician and three consultants pronounced it cancer, and advised operation, but frankly told her that it was too late, as there had developed tumors in the right breast and additional ones in the left. When she consulted me examination showed the following: Both breasts large and dependent; nipples not retracted; no palpable glands in the axilla of either side; some enlarged glands in the left axillary line, close to the breast; a lumpy condition of the right breast; the left breast the seat of a large, soft fibro-adenoma, in the lower inner quadrant. The patient was sent to the New York Skin and Cancer Hospital for operation. The multiple adenomata were removed by the conservative method—incision under each breast, the breast lifted up, the tumors removed, leaving the glandular structures intact,—and the configuration of the breasts preserved. Pathological examination verified the clinical diagnosis of adenoma.

The patient's general health, which had been very poor for a number of years, improved under rest, and dietary and tonic treatment, plus, perhaps, the psychic benefit of the knowledge that she was not, after all, the doomed victim of cancer. She has since been perfectly well.

Case 9. J., female, 65 years of age, widow. Referred by Dr. Winifred D. Banks, East Orange, N. J., January 26, 1915, for advice concerning a large pelvic mass (fibroid with probable malignant de-

generation). In July, 1914, eighteen years after the establishment of the menopause, the patient began to have a uterine discharge of pus and blood, continuous, but sometimes more profuse than at others. There was progressive loss of flesh and strength, and almost total obstruction of the bowel. Laparotomy was advised, with hysterectomy, and the correction of other abdominal conditions that might be found. This was performed at the New York Polyclinic Hospital, Feb. 17, 1915, with the following findings: A loop of the ileum



CASE 9. Fig. XV.

was adherent to the fundus uteri and acutely angulated (Fig. 15); a loop of the pelvic colon was similarly adherent, (Fig. 16). These adhesions were freed with great difficulty, it being necessary to dissect down to the mucous membrane of the gut before the bowel could be detached from the uterus. On the fundus uteri was a softened, degenerated, inflammatory mass, probably a fibroid cyst, to which the ileum and pelvic colon had adhered. Between the knuckles of the loop of ileum, which was almost completely obstructed, was a mass of pus and the left fallopian

tube. The uterus was greatly enlarged, filling the entire pelvis. A portion of the tissue removed from the adherent intestine and uterus was immediately examined under the microscope, and found to be inflammatory. No resection of gut was therefore deemed necessary, but the uterus was completely removed. Multiple fibroids had formed, which had degenerated and formed a pus sac in the pelvic cavity, surrounded by intestines and uterus. The bladder was



CASE 9. Fig. XVI.

tightly adherent to the mass and formed part of the abscess wall. In order to dissect away the bladder that organ was opened and later closed. The patient made an uneventful recovery and has gradually improved in health and strength.

This patient had been told by several physicians who examined her that she had irremovable cancer of the pelvic organs, and that operation was useless. Her complete recovery justifies the willingness to

take a chance in a seemingly very doubtful case.

Case 10. E., male, 45 years of age. Consulted me November 13, 1909, for what had been pronounced by four doctors irremovable cancer of the rectum. Despite this prognosis, he was admitted to the New York Skin and Cancer Hospital, and on November 19, 1909, I removed the rectum from below, saving the sphincter, bringing the end of the gut down and suturing it in place. On March 16, 1911, a small recurrence, resembling a hemorrhoid, was removed. Since that time he has been perfectly well. The last examination, May 29, 1915, showed no evidence of recurrence.

With only a slight recurrence in the year and a quarter after the removal of the rectum, and with an interval of four years of freedom from recurrence, there is a fair chance that the man will have no further trouble. Even should there be a further recurrence, he has had more than five years of relief from the deplorable condition in which I found him—an excellent example of, at least a seeming cure of the seemingly incurable.

Case 11. S., female, widow, aged 44. Referred by Dr. Eliza M. Mosher, of Brooklyn, November, 1910. The diagnosis of irremovable cancer of the uterus had been made by two surgeons. Examination gave evidence of advanced cancer of the uterus, with apparent involvement of the broad ligaments and pelvic glands. Operation at Alston's Private Hospital, November 15, 1910. Arterial ligation of the pelvic vessels, with lymphatic block; panhysterectomy, with vaginectomy (Wertheim). Uneventful recovery. Pathological exam-

ination by several pathologists confirmed the diagnosis of carcinoma. The patient is perfectly well to-day, four and a half years after the operation, and after she had been repeatedly pronounced "inoperable" and "incurable."

It is held by some surgeons that when glands are palpable in a case of cancer of the uterus, it is too late for even a Wertheim operation. Had this opinion been followed in this case the patient would have been left to unnecessary suffering and early death. As it was, by tying off the blood-vessels and removing the glands along the ureters, from the obturator foramen to the receptaculum chyli, it became possible to do what seemed impossible before, and a complete removal of all macroscopic evidence of the disease was effected. Inasmuch as four years and a half have brought no recurrence, presumably all microscopic disease also was removed.¹

Case 12. H.,² female, 54 years of age. Referred by Dr. Henry Hughes, West Long Branch, N. J., November 10, 1909. The patient had had rectal trouble, with chronic constipation, for three years. In May, laparotomy was performed by another surgeon, with the purpose of removing a cancer of the lower bowel. So many adhesions were found, however, that nothing was done, the case being considered one of inoperable cancer, with general visceral

¹ Bainbridge,—“Arterial Ligation for Irremovable Cancer of the Pelvic Organs: Technic Adapted and Amplified.” *Woman's Med. Jour.*, April, 1911.

² Reported in: “Possible Errors in the Diagnosis of Abdominal Cancer; A Plea for Exploratory Laparotomy; Illustrative Cases.” *New York State Med. Jour.*, October, 1913.

extension. She was markedly cachectic when I first saw her, had experienced great loss of flesh and strength, and was suffering from the evil effects of almost total obstruction of the lower pelvic colon by the advanced cancer of the rectum.

Exploratory laparotomy, November 22, 1908, with the hope that the first operator had been mistaken in the extent of the disease, and believing that if this were not the case, a colotomy would give relief. Extensive adhesions were found, but they were clearly from an old peritonitis following childbirth, years before, and from the previous operation. These were separated. Diseased left ovary and tube were found, and salpingo-oöphorectomy was performed. By the combined operation, using the vaginal outlet, $2\frac{1}{2}$ feet of intestine, with mesorectum and meso-sigmoid, were removed. The cut end of the rectum was brought into the pelvis. The sphincter, with the last two inches of the rectum, was saved. The patient made an uneventful recovery, has fair control of her bowels, and when last seen, June 1, 1915, was perfectly well.

In this case the error in diagnosis was not with reference to the disease, but with reference to the stage thereof, and its operability and curability. The seemingly hopeless condition was due to complications which, in themselves, were not of serious moment so far as prognosis was concerned. The correction of these complications changed the entire aspect of the case.

This patient further serves to emphasize the importance of differentiating between malignant and nonmalignant adhesions, between an inflammatory condition of the tubes and ovaries (which pathological examination proved to be the case here, with

no malignancy present), and cancer. Valuable time was lost by the failure to recognize these differences, and the patient's life was thereby placed in jeopardy.

In this series of twelve cases, which might be multiplied many times, may be found illustrations of all the classes of cases mentioned in the beginning, except the last—the inoperable, irremovable, and incurable. In each instance there had been a gloomy prognosis with reference to the operability, and certainly with reference to the curability of the condition. Yet every patient is alive and well to-day, with the one exception of the patient in Case 7, who died of post-operative pneumonia. The prognosis was not especially favorable in her case, because of the long delay, and yet, but for the unfortunate contingency which arose, she, too, might be alive and well.

It is my purpose here, therefore, not to record unique cases or new and striking methods of treatment, but rather to emphasize the importance of giving the patient the benefit of every possible doubt in favor of palliation or cure. Those who have followed the progress of surgery closely know full well that the day of miracles is still with us, for feats are being accomplished all the while which a few years ago would have been considered impossible.

Such cases, furthermore, serve to show how much work is yet to be accomplished within the medical profession, before the campaign of education may be very broadly extended among the public at large without fostering an element of harm which may outweigh the modicum of good.

